MAXIMUS Federal Services

Case Number:	CM14-0034431		
Date Assigned:	06/20/2014	Date of Injury:	09/10/2009
Decision Date:	07/24/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	03/19/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in New York and Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 61 year old female who had a work related injury on 09/10/09. The injured worker has had multiple treatments over the years to include physical therapy, aquatic therapy, nonsteroidal anti-inflammatories, pain medication. The injured worker has also had a psychological evaluation on 10/30/10 wherein a diagnosis was made of fibromyalgia since 1998. Examination from 02/07/14 indicates that the injured worker continued with significant pain in her neck and lower back. The injured worker also noted some gastritis and right sided abdominal pain. No documentation of functional improvement or decrease in pain. An examination of the cervical spine noted muscle spasm in the paracentral musculature. The injured worker range of motion was noted as limited. The lumbar exam revealed muscle spasm in the paralumbar musculature. Range of motion is decreased. There is diminished sensation in the L4 nerve distribution of the right lower extremity. The plan is for restoration program for her chronic pain and medication. The current request is for Tramadol ER 150 mg #30, Ondanestron 4 mg #30. Diagnosis is fibromyalgia, left wrist intercarpal ligamental tear, bilateral knee chondromalacia, metatarsalgia, multilevel lumbar spondylosis, adjustment disorder/somatoform disorder, bilateral CMC arthritis.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Ondanestron 4mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines/Pain Chapter, Anti-emetics.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Antiemetics (for opioid nausea).

Decision rationale: The request for Ondansetron 4 mg #30 is not medically necessary. The clinical documentation submitted for review, and current the ODG do not support the request. This drug is a serotonin 5-HT3 receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy, radiation treatment, and postoperative use. It has also been FDA-approved for acute gastroenteritis. Therefore medical necessity has not been established.

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Tramadol (UltramÂ®).

Decision rationale: The request for Tramadol ER 150 mg #30 is not medically necessary. The injured worker also noted some gastritis and right sided abdominal pain. The clinical documentation submitted for review, does not show functional improvement or decrease in pain. Therefore, medical necessity has not been established.